Title: Comment on the Consensus Report on the Management of Hyperglycemia in Type 2 Diabetes by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD).

We read with interest the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) joint Consensus Report on the Management of Hyperglycemia in Type 2 Diabetes [1]. Following the publication of the report, discussions of the content among networks of behavioural and educational researchers prompted us to write this letter

This consensus report is to be commended for recommending that "providers and health care systems should prioritize the delivery of patient-centered care". The report is also to be commended for providing some clear actions that can be taken to promote person-centred care, including emphasizing the importance of diabetes self-management education and support, promoting shared decision-making between the person with diabetes and the health care professional, and pointing to some methods that may be beneficial in achieving this. At the same time, we also appreciate that there are challenges in implementing a person-centred approach and we would like to highlight and comment on some of these challenges we see in the Consensus Report.

The first is that the report uses the term "adherence" throughout, making the recommendation that "Facilitating medication adherence should be specifically considered when selecting glucose-lowering medications". Whilst we agree that it is important to discuss the issues surrounding an individual's willingness and ability to take any prescribed medications, we suggest that the word "adherence" is used ill-advisedly in the report. A recent series of position statements from Diabetes Australia [2], jointly by the ADA and American Association of Diabetes Educators [3] and jointly by Diabetes UK and the UK's National Health Service [4], have pointed to the negative consequences of using the terms "adherence" and "compliance", when talking with or about people living with diabetes. These position statements echo earlier commentaries that argue that compliance and adherence are dysfunctional concepts and empirical work demonstrating that the assumptions underpinning these words are not substantiated [5]. The continued use of the term "adherence", which implies an unequal relationship in which people with diabetes passively follow clinicians' instructions, is at best unhelpful. The fact that diabetes care is largely stuck in this "adherence" paradigm may explain why a series of Cochrane reviews on interventions to promote adherence

have repeatedly concluded that "Current methods of improving medication adherence for chronic health problems are mostly complex and not very effective" [6], and argued that the problem needs to be reconceptualised. This can be done readily by active adoption of a "strengths-based, empowering language" [3] and other recommendations of the above-mentioned position statements [2-4] to facilitate active engagement in self-care, health and well-being.

We are also concerned with the statement that "effective consultations include motivational interviewing". "Motivational interviewing" is a specific set of intervention strategies and techniques requiring extensive training and significant time to deliver. Consequently, it is not possible for most health professionals to include "motivational interviewing" in routine clinical and education practice. Furthermore, recommendations for integrating a specific set of tools and techniques into clinical practice require a high-quality evidence base. However, this does not exist for motivational interviewing in diabetes or chronic disease care [7]. Whilst meta-analyses indicate a possible small benefit of such interventions, this is conflated with the additional time investment. We suggest that the emphasis needs to be placed not on specific methods but on the principles underpinning "motivational interviewing", common to many effective psycho-educational interventions and essential to effective diabetes care. These principles move the clinician away from an "adherence" paradigm, to focus not on persuading the person with diabetes to take a certain medication, but rather to raise awareness of the individual's choices and enable agreement about which management option best fits the individual's needs, goals, values and preferences.

As part of the goal to individualise care, the Consensus Report also provides guidance on the assessment of "key patient characteristics"; specifically, recommending assessment of "Issues such as motivation and depression". This seems at odds with ADA's 2016 position statement on the psychosocial care of people with diabetes, which recommends considering an "assessment of symptoms of diabetes distress, depression, anxiety, and disordered eating and of cognitive capacities" [8], and the ADA's 2019 standards of diabetes care [9]. Thus, we are surprised that this joint Consensus Report does not specifically recommend assessment of diabetes distress, especially given a recent meta-analysis, which indicates that about one third of individuals with type 2 diabetes experience clinically significant levels of diabetes distress [10]. We are also surprised that the report recommends the assessment of "motivation", given that this term is vague, often used inappropriately, and is not easily assessed. We acknowledge that achieving a paradigm shift takes time, and requires persistent, consistent and insistent

advocacy. However, it is disappointing that this joint Consensus Report does not appear to be implementing the recent recommendations of the ADA, and other international bodies, to incorporate strengths-based language and related strategies, with the aim of enabling widespread promotion of truly person-centred diabetes care. Therefore, we would like to recommend that future similar endeavours (consensus reports, guidelines, position statements) include representation of a broader range of disciplines and relevant associations and study groups e.g. American Association of Diabetes Educators (AADE), Psycho-Social Aspects of Diabetes Study (PSAD) group of the EASD, and the U.S. based Behavioral Research In Diabetes Group Exchange (BRIDGE).

Funding: None

Conficts of interest: The authors declare no conflicts of interest

Disclaimer: The opinions expressed in this letter reflect those of the authors and not of their institutional affiliations.

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Word count: 870
Tables / Figures: 0
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